

**MARYLAND MEDICAL ASSISTANCE PROGRAM  
CERTIFICATION FOR ABORTION**

A COPY OF THIS FORM MUST BE ATTACHED TO ALL INVOICES FOR ABORTION SERVICES.

Please Print or Type

PATIENT'S NAME

PHYSICIAN COMPLETING FORM

PATIENT'S ADDRESS

PHYSICIAN'S MEDICAL ASSISTANCE PROVIDER NUMBER

PATIENT'S ADDRESS

PLACE OF SERVICE

PATIENT'S MEDICAL ASSISTANCE NUMBER

DATE OF SERVICE

**PART I - Check one of the blocks if applicable and sign the certification.**

- ☐ G. I certify that this abortion is necessary because the life of the mother would be endangered if the fetus were carried to term.

DATE

PHYSICIAN'S SIGNATURE

- ☐ I. Attached is a document submitted by an official of a law enforcement agency or public health service where the rape or incest was reported. The document includes the following information:

1. Name and address of victim;
2. Name and address of person making the report (if different from the victim);
3. Date of the rape or incest incident;
4. Date of the report (may not exceed 60 days after the incident);
5. Statement that the report was signed by the person making it;
6. Name and signature of person at law enforcement agency or public health service who took the rape or incest report.

DATE

PHYSICIAN'S SIGNATURE

**PART II - You must check one of the following blocks and sign the certificate, unless you have checked "I" in Part I, above.**

- ☐ R. I certify that this abortion is necessary because, based on my professional judgement, continuation of the pregnancy is likely to result in the death of the woman.

DATE

PHYSICIAN'S SIGNATURE

- ☐ S. I certify that, within a reasonable degree of medical certainty, based on my professional judgement, termination of pregnancy is medically necessary because there is substantial risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.

DATE

PHYSICIAN'S SIGNATURE

- ☐ T. I certify that, in my professional judgement, there exists medical evidence that continuation of the pregnancy is creating a serious effect on the woman's present mental health and, if carried to term, there is substantial risk of a serious or long lasting effect on the woman's future mental health.

DATE

PHYSICIAN'S SIGNATURE

- ☐ V. I certify that, within a reasonable degree of medical certainty, based on my professional judgement, this abortion is necessary because the fetus is affected by genetic defect or serious deformity or abnormality.

DATE

PHYSICIAN'S SIGNATURE

- ☐ W. I certify that this procedure is necessary for a victim of rape, sexual offense, or incest, and the incident has been reported to a law enforcement agency or to a public health or social agency.

DATE

PHYSICIAN'S SIGNATURE

MARYLAND MEDICAL ASSISTANCE PROGRAM  
DOCUMENT FOR HYSTERECTOMY

COPY OF THIS FORM MUST BE ATTACHED TO ALL INVOICES FOR HYSTERECTOMIES:

Please Print or Type

PATIENT'S NAME

PHYSICIAN COMPLETING FORM

PATIENT'S ADDRESS

PHYSICIAN'S MEDICAL ASSISTANCE NUMBER

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PATIENT'S MEDICAL ASSISTANCE NUMBER

PLACE OF SERVICE

DATE OF SERVICE

SECTION I - To be signed by physician and patient or patient's representative when patient has been informed of the service.

A. I have performed a hysterectomy on \_\_\_\_\_ . I hereby certify  
that the following conditions do not apply to this hysterectomy. (NAME OF PATIENT)

1. It was performed solely for the purpose of rendering the individual permanently incapable of reproducing;  
or
2. If there was more than one purpose to the procedure, it would not have been performed but for the purpose  
of rendering the individual permanently incapable of reproducing.

I have informed the patient and her representative, if any, orally and in writing, that the hysterectomy will make  
the patient permanently incapable of reproducing.

DATE

SIGNATURE OF PHYSICIAN

B. Receipt of Hysterectomy Information

I, \_\_\_\_\_ have been informed by  
(NAME OF PATIENT)

\_\_\_\_\_, that the hysterectomy to be  
(NAME OF PHYSICIAN)  
performed will render me permanently incapable of reproducing.

DATE

SIGNATURE OF PATIENT OR REPRESENTATIVE

SECTION II - To be signed by physician. No patient signature is needed because the individual:

A. Was already sterile before the hysterectomy due to \_\_\_\_\_ : or  
(CAUSE OF STERILITY)

B. Required a hysterectomy performed under a life-threatening emergency situation in which prior acknowledge-  
ment was not possible. (Describe the nature of the emergency.)

DATE

SIGNATURE OF PHYSICIAN

**MARYLAND MEDICAL ASSISTANCE PROGRAM  
STERILIZATION CONSENT FORM**

**NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.**

■ **CONSENT TO STERILIZATION** ■

I have asked for and received information about sterilization from \_\_\_\_\_  
(doctor or clinic)

When I first asked for the information I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as \_\_\_\_\_. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on \_\_\_\_\_  
Month Day Year

I, \_\_\_\_\_, hereby consent of my own free will to be sterilized by \_\_\_\_\_  
(doctor)

by a method called \_\_\_\_\_. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health, Education, and Welfare or

Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.

I have received a copy of this form.

\_\_\_\_\_  
Signature Date: \_\_\_\_\_  
Month Day Year

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check)

- |   |   |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black (not of Hispanic origin) |
| <input type="checkbox"/> Asian or Pacific Islander        | <input type="checkbox"/> Hispanic                       |
|   | <input type="checkbox"/> White (not of Hispanic origin) |

■ **INTERPRETER'S STATEMENT** ■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I

have also read him/her the consent form in \_\_\_\_\_ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

\_\_\_\_\_  
Interpreter

\_\_\_\_\_  
Date

■ **STATEMENT OF PERSON OBTAINING CONSENT** ■

Before \_\_\_\_\_ signed the  
name of individual  
consent form, I explained to him/her the nature of the sterilization operation \_\_\_\_\_ the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

\_\_\_\_\_  
Signature of person obtaining consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Facility

\_\_\_\_\_  
Address

■ **PHYSICIAN'S STATEMENT** ■

Shortly before I performed a sterilization operation upon \_\_\_\_\_  
Name of individual to be sterilized Date of sterilization

\_\_\_\_\_, I explained to him/her the nature of the operation \_\_\_\_\_, the fact that sterilization operation \_\_\_\_\_  
specify type of operation

it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery  
☐ Individual's expected date of delivery:  
☐ Emergency abdominal surgery:

(describe circumstances):

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Date

## SECTION I - Patient Information

Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
 (Last) (First) (MI)

Address \_\_\_\_\_

Pay to Provider Number 

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 Request Date \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

Contact \_\_\_\_\_

Provider's Signature \_\_\_\_\_

Referring Provider	Rendering Provider
<input type="text"/>	<input type="text"/>
Name <input type="text"/>	Name <input type="text"/>
Address <input type="text"/>	Address <input type="text"/>
	Telephone ( <input type="text"/> ) <input type="text"/>
Dates of Service: From: <input type="text"/> Thru: <input type="text"/>	
Diagnosis Codes: 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/>	

## DEPARTMENT USE ONLY


A. Complete Narrative Justification for procedure(s)  
B. Brief history and physical examination  
C. Result of pertinent ancillary studies if applicable  
D. Pertinent medical evaluations and consultations if applicable

\_\_\_\_\_

SUBMIT TO: Program Systems and Operations Administration  
Division of Claims Processing  
P.O. Box 17058  
Baltimore, Maryland 21203

DOCUMENT CONTROL NUMBER  
(STAMP HERE)